DEPARTMI **320-01**

38 CFR Part 17

RIN 2900-AQ45

Veterans Care Agreements

AGENCY: Department of Veterans Affairs.

ACTION: Final rule.

SUMMARY: The Department of Veterans Affairs (VA) adopts as final, with no substantive changes, an interim final rule revising its medical regulations to implement VA's authority under section 102 of the John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (MISSION Act), which authorizes VA to enter into agreements to furnish required hospital care, medical services, and extended care services in the community when such care and services are not feasibly available to certain individuals through a VA facility, a contract, or a sharing agreement. As specified in section 1703A and this implementing rule, these agreements are called Veterans Care Agreements (VCA).

DATES: This rule is effective on **[insert date 30 days after the date of publication in the FEDERAL REGISTER].**

FOR FURTHER INFORMATION CONTACT: Joseph Duran, Office of Community Care (10D), Veterans Health Administration, Department of Veterans Affairs, Ptarmigan at Cherry Creek, Denver, CO, 80209; (303) 372-4629. (This is not a toll-free number.)

SUPPLEMENTARY INFORMATION: On June 6, 2018, the President signed into law the John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018, Pub. L. No. 115-182, 132 Stat. 1393 (2018) (codified as amended in scattered sections of 38 U.S.C.) (MISSION Act). This rule adopts as final, with no substantive changes, an

interim final rule revising VA medical regulations to implement section 102 of the MISSION Act (codified as amended at 38 U.S.C. 1703A), which authorizes VA to enter into agreements to furnish required hospital care, medical services, and extended care services in the community when such care and services are not feasibly available to certain individuals through a VA facility, a contract, or a sharing agreement. As specified in section 1703A and this implementing rule, these agreements are called Veterans Care Agreements (VCA).

On May 14, 2019, VA published an interim final rule to establish the parameters of VCAs authorized under section 1703A, to include: establishing a certification process for entities and providers that will seek to enter into a VCA and furnish care or services pursuant to that agreement; establishing certain parameters governing the payment rates that will be set forth in the terms of each VCA; and establishing an administrative process for adjudicating disputes arising under or related to VCAs, including those pertaining to claims for payment for care or services provided under a VCA. 84 FR 21668. VA received input from eight commenters in response to this interim final rule, only three of which raised issues relevant to the rule. VA's responses to those three commenters are summarized below.

One commenter that represents a membership consisting of long term and post-acute care providers offered four comments that relate to VA's implementation and use of VCAs. The comments do not expressly or impliedly request any changes to the interim final rule, nor do they raise any issues that would necessitate or merit any such changes.

First, the commenter noted that it wants to ensure its members obtain access to information "available at both the regional and national levels" within VA regarding VA's implementation and use of VCAs. Relatedly, the commenter also indicated that it has heard from some of its members that they would like VA to establish one or more points

of contact at the "national" level that providers could communicate with directly when they have questions that "regional" VA offices are unable to answer regarding VA's implementation and use of VCAs. We interpret the commenter's references to information made available and points of contact established at the "national" and "regional" levels to constitute references to when such information and resources are made available by national offices of the Veterans Health Administration (VHA) as compared to when they are made available by Veterans Integrated Service Networks (VISN) or by individual VHA medical facilities. In response to the commenter's input in this regard, we note that VA currently uses a mix of organizational components and points of contact to make information relating to VA's implementation and use of VCAs available to entities and providers. Certain information, resources, and points of contact are made available at the national organizational level through the website of VHA's national Office of Community Care.[1] For example, VA provides access to relevant provider educational and training resources (e.g., webinars of the type incidentally mentioned in the same comment), and a related national point of contact, in this manner.[2] However, VA also currently makes certain information, resources, and points of contact available only through the individual VHA medical facilities that enter into and administer the specific VCAs to which such information, resources, and points of contact relate. Applications for certification under section 17.4110 of the interim final rule are processed, and VCAs are entered into and administered, by officials at local VHA medical facilities. Consequently, those officials and the local facility staff are often the most reliable and efficient sources of relevant and accurate information for an entity or provider that is considering or is currently navigating the processes of applying for certification, entering into a VCA with that local facility, and/or furnishing hospital care,

[1] *See* https://www.va.gov/communitycare/ (last accessed 9/8/2021).
[2] *See* https://www.va.gov/communitycare/providers/EDU_Training.asp (last accessed 9/8/2021).

medical services, or extended care services pursuant to a VCA that the entity or provider previously entered into with that local facility. Moreover, even in instances where the responsible local officials lack certain information requested by an entity or provider regarding those matters, it is important that those local officials remain the applicable VA points of contact for such entities and providers regarding those matters. Local officials possess the authority and responsibility for many aspects of the implementation and use of VCAs at each local VHA medical facility, so ensuring that they are privy to and the source of communications to entities and providers regarding those matters (e.g., status of a provider's certification, terms of a provider's VCA, or issues pertaining to specific authorizations or claims) promotes consistency and efficiency in VA's use and administration of VCAs and mitigates risk of conflicting communications from those lacking the authority and responsibility for those aspects of VA's implementation and use of the specific local VCAs and processes that are the subject of such communications. If the responsible officials at local VHA facilities lack certain information requested by an entity or provider regarding implementation and use of VCAs at that facility, those officials can and do utilize established internal communication channels to consult with VISN and national VHA offices, including the Office of Community Care, as appropriate, in identifying such information and formulating an appropriate response.

In its second comment, the same commenter noted that it wants to ensure that the Centers for Medicare & Medicaid Services (CMS) and VA communicate how CMS' Patient Driven Payment Model (PDPM), which became effective on October 1, 2019, and the VCA reimbursement structures will work together. As it pertains to VA, we interpret this comment as requesting that VA communicate whether and to what extent the rates that VA pays for care and services furnished by nursing facilities pursuant to VCAs are based upon or influenced by CMS' PDPM case-mix classification

methodology for calculating Part A payments under Medicare's skilled nursing facility prospective payment system (SNF PPS). As established in § 17.4120 of the interim final rule, that information (i.e., the nexus between CMS' PDPM methodologies and rates and VA payment methodologies and rates, if any), when applicable, will be communicated by VA in the price terms set forth in the specific VCA pursuant to which VA obtains the care or services at issue. Specifically, as established in § 17.4120 of the interim final rule, the rates paid by VA for hospital care, medical services, and extended care services furnished pursuant to a VCA will be the rates set forth in the price terms of that specific VCA, and those price terms will be established in compliance with the general parameters set forth in § 17.4120(a)-(e). One such parameter of particular relevance to this comment regarding CMS' PDPM is contained in § 17.4120(a), which provides in pertinent part that, subject to the caveats and exceptions set forth in § 17.4120(b)-(e), payment rates for services furnished pursuant to VCAs will not exceed the applicable Medicare prospective payment system amount, if any, for the period in which the service was provided (without any changes based on the subsequent development of information under Medicare authorities). Given that Medicare's SNF PPS is a "prospective payment system" within the meaning of the foregoing limitation, and given that CMS' PDPM currently governs how payment amounts are calculated under the SNF PPS, the PDPM will necessarily be factored into VA's calculus when formulating certain VCA payment rates that are subject to the general limitation set forth in § 17.4120(a). However, while the general limitation in § 17.4120(a) can affect how VA formulates pricing for care and services obtained pursuant to VCAs, we emphasize that it is subject to the caveats and exceptions set forth in § 17.4120(b)-(e) and we note that the existence of that general limitation does not require or mean that the price terms set forth in any specific VCA for care and services furnished by nursing facilities will be the same as or based upon the payment rates, if any, for the same services

under CMS' PDPM. Instead, as previously stated, the nexus between CMS' PDPM methodologies and rates and VA payment methodologies and rates, if any, will be communicated by VA in the price terms set forth in the specific VCA pursuant to which VA obtains the care or services at issue.

In its third comment, the same commenter indicated that providers might be hesitant to enter into VCAs until the U.S. Department of Labor's Office of Federal Contract Compliance Programs (OFCCP) issues a Notice of Proposed Rulemaking (NPRM) that would revise certain portions of 41 CFR subtitle B, chapter 60 that concern the obligations of TRICARE and certain other health care providers, as federal contractors and/or subcontractors, under the nondiscrimination and affirmative action provisions of Executive Order (E.O.) 11246 (as amended), section 503 of the Rehabilitation Act of 1973 (as amended), and the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (as amended). We interpret this comment as referring to the NPRM subsequently published by OFCCP at 84 FR 59746 (Nov. 6, 2019). That NPRM culminated in a final rule, published by OFCCP at 85 FR 39834 (Jul. 2, 2020), that revised certain definitions set forth in 41 CFR 60-1.3, 60-300.2, and 60-741.2. Given that the rulemaking referenced in this comment has been completed, the commenter's concern that providers might be hesitant to enter into VCAs until the completion of that rulemaking process is no longer applicable.

In its fourth and final comment, the same commenter stated that it wants to ensure that "services covered under VA contracts will continue to be covered under VCAs." While the intended meaning of this comment is unclear to us, we note that, in accordance with the statutory authority for VCAs and the interim final rule, VA can use VCAs to obtain "hospital care" (as defined in 38 U.S.C. 1701(5)), "medical services" (as defined 38 U.S.C. 1701(6)), and "extended care services" (defined as the services

described in 38 U.S.C. 1710B(a)).[3] We also note that the circumstances when VA is legally authorized to use VCAs to obtain hospital care, medical services, or extended care services are specified in 38 U.S.C. 1703A(a) and in § 17.4115(a) of the interim final rule. Consequently, we do not make any changes to the interim final rule based on this comment.

One commenter that represents a membership consisting of hearing health care professionals, including licensed hearing aid specialists, offered several comments in response to the interim final rule. Some of those comments pertain to matters that are outside the scope of this rulemaking and which do not implicate any considerations that would necessitate or merit any changes to the interim final rule. For example, the commenter urged VA to develop and implement the qualifications, which VA is authorized to prescribe pursuant to 38 U.S.C. 7402(b)(14), for hearing aid specialists appointed to positions in VHA in accordance with 38 U.S.C. 7401. The commenter also urged VA to include hearing aid specialists appointed pursuant to 38 U.S.C. 7401 in the audiology teams that operate in VHA facilities. The government personnel matters raised in these comments, including whether and when VA develops qualifications for hearing aid specialists appointed to positions in VHA, and how VA utilizes any such specialists in VHA facilities, are outside the scope of this rulemaking and implicate no issues bearing on the contents of the interim final rule.

The same commenter also urged VA to prioritize delivery of hearing-related health care services to veterans, both in VHA facilities and through "the Community Care Program," a phrase that we interpret to be a reference to the Veterans Community Care Program (VCCP) established by section 101 of the MISSION Act (codified as

[3] *See* 38 U.S.C. 1703A(a)(1)(A) (authorizing VA to use VCAs to obtain "hospital care, a medical service, or an extended care service" in certain circumstances); 38 U.S.C. 1701(5)-(6) (defining the terms "hospital care" and "medical services" for purposes of 38 U.S.C. chapter 17, which includes section 1703A); 38 CFR 17.4100 (defining the terms "hospital care," "medical services," and "extended care services" for purposes of sections 17.4100-17.4135).

amended at 38 U.S.C. 1703). The matters raised in this comment, including whether and to what extent VA can and does prioritize the provision of certain types of hospital care, medical services, and extended care services in VHA facilities or through the VCCP, are matters outside the scope of this rulemaking. Moreover, to the extent the commenter is concerned about VA electing to adopt regulatory parameters that restrict VA's ability to provide hearing-related health care services through VCAs, we note that the interim final rule contains no such elective restrictions. The interim final rule authorizes VA to use VCAs to obtain any of the types of hospital care, medical services, and extended care services permitted by the underlying statutory authority, 38 U.S.C. 1703A.

The commenter also recommended that VA use licensed hearing aid specialists and audiologists to provide hearing aid evaluations, hearing aid fittings, and related services when veterans are receiving such services through "the Community Care Program," a phrase that, as previously noted, we interpret to be a reference to the VCCP. The matters raised in this comment, including whether and to what extent certain specific types of providers furnish the care and services that VA obtains for covered veterans through the VCCP, are matters outside the scope of this rulemaking. Moreover, to the extent the commenter is concerned about VA electing to adopt regulatory parameters that restrict VA's ability to use VCAs to obtain care and services furnished by licensed hearing aid specialists and audiologists, we note that the interim final rule contains no such elective restrictions. For example, the certification process set forth in § 17.4110 of the interim final rule contains no requirements or approval criteria that would fundamentally preclude VA from granting certification to licensed hearing aid specialists and audiologists or that are any more restrictive with regard to those types of providers than they are for any other type of provider or entity seeking certification.

In addition to providing the general comments described above, the same commenter also suggested two changes to the text of the interim final rule. First, the commenter suggested that VA replace the term "medical" in § 17.4110(b)(1)(i) with the term "health care" so that the licensure documentation requirement in that subparagraph encompasses health care professionals other than physicians. In response, we clarify that the requirement in that subparagraph to provide documentation of "applicable medical licenses" does not preclude health care professionals other than physicians from applying for and receiving certification under § 17.4110. If the applicant does not possess a medical license, then there are no "applicable medical licenses" of which the applicant must submit documentation under that subparagraph. Moreover, we also note that under § 17.4110(b)(1)(ii), VA can require applicants to submit documentation of relevant licenses other than medical licenses. Consequently, because the result apparently sought by the commenter—VA's certification process accommodating the submission of documentation of licenses from health care professionals other than physicians—is already provided for in the existing language of the interim final rule, VA does not adopt the change recommended in this comment. The commenter also indicated that the payment rate parameters set forth in § 17.4120(a)-(b) of the interim final rule, which are expressly tied to Medicare payment models, should be revised to allow for the establishment of fee schedules for services that are not within the scope of those Medicare-related parameters, such as hearing tests for the provision of hearing aids and related hearing aid services. In response, VA notes that the payment rate parameters set forth in § 17.4120 of the interim final rule already permit the very result that the commenter is seeking. Under § 17.4120, the rates paid by VA for hospital care, medical services, or extended care services furnished pursuant to a VCA are the rates set forth in the price terms of that specific VCA, and, when the Medicare-related parameters set forth in § 17.4120(a)-(b) do not

apply to the care or services at issue, VA is permitted to establish the payment rates for such care or services based on a fee schedule or some other formulation that is unrelated to Medicare payment rates and methodologies. Given that the result sought by the commenter is already permitted under the existing language of the interim final rule, VA makes no changes based on this comment.

A commenter that operates a psychiatric facility raised multiple issues. First, the commenter noted that veterans often face specialized mental health needs, including "combat related" needs such as those resulting from post-traumatic stress disorder (PTSD) or traumatic brain injury (TBI). In light of VA's specialized experience in those clinical areas, the commenter urged VA to share its knowledge of "combat related illnesses" with mental health providers and indicated that VA should require mental health providers furnishing care pursuant to VCAs to be adequately trained to handle mental health needs that are unique to or more frequently experienced by veterans. In this regard, the commenter specifically recommended that the certification process in § 17.4110 of the interim final rule should require special training in the area of mental health. We interpret this recommendation to mean that such training should be required solely for mental health providers and should pertain to those clinical areas for which VA has special expertise, including PTSD and TBI. In response, we note that VA agrees that it is critical for veterans to receive competent care from qualified non-VA providers and that VA can contribute to that result in certain instances by providing training and/or education to non-VA providers in clinical areas for which VA has special expertise, including PTSD and TBI. In this regard, we note that VA will take a number of actions that will result in the provision of relevant training and education to non-VA providers furnishing care and services authorized pursuant to VCAs. For example, in accordance with section 133 of the MISSION Act (codified at 38 U.S.C. 1701 note), VA established competency standards and requirements, including training requirements, for the

provision of care by non-VA providers in clinical areas for which VA has special expertise, including PTSD and TBI. Such requirements apply to providers furnishing care and services pursuant to VCAs. Also, in accordance with section 123 of the MISSION Act (codified at 38 U.S.C. 1701 note), VA established a program to provide continuing medical education to non-VA medical professionals furnishing care to VA beneficiaries, including pursuant to VCAs. Moreover, VA provides appropriate oversight of care and services furnished pursuant to VCAs as VA administers those agreements. For example, VA established and imposed quality standards in accordance with 38 U.S.C. 1703C and monitors and assess the quality of the care and services provided pursuant to VCAs in accordance with 38 U.S.C. 1703A(g). However, adding specific training requirements to the certification process in § 17.4110 through the regulation process, as opposed through the VCA agreements themselves, would not be an appropriate means of establishing such training requirements and ensuring that non-VA providers fulfill the appropriate training requirements prior to furnishing mental health care that VA obtains through VCAs in clinical areas for which VA has special expertise, including PTSD and TBI. Training requirements for mental health providers furnishing care and services pursuant to VCAs may need to be changed over time, potentially quickly in certain instances, for reasons including developments in clinical practice or new legal requirements with which VA must comply. So, establishing training requirements in the terms of VCAs, rather than in the certification process set forth in the final rule resulting from this rulemaking, will ensure VA retains the flexibility to more quickly and efficiently adjust those training requirements as appropriate based on evolving circumstances and requirements. For the foregoing reasons, we do not adopt the commenter's recommendation to add a training requirement to the certification process set forth in § 17.4110 of the interim final rule.

The same commenter also provided recommendations regarding the authority set forth in § 17.4020(d) of the interim final rule, which authorizes VA to establish payment rates exceeding the applicable Medicare-based limitations in § 17.4120(a)-(b) when VA determines that it is not practicable to limit payment to those rates. Specifically, the commenter recommended that the authority to make the determinations referenced in § 17.4120(d) should be delegated to officials at individual VHA medical facilities and should not be subject to an overly burdensome justification and approval process. In response, VA notes that although the authority to generate determinations referenced in § 17.4120(d) of the interim final rule is delegated to officials at individual VHA medical facilities, that authority is circumscribed by a requirement that each such determination must be approved by VHA's national Office of Community Care. This centralized oversight by the Office of Community Care is intended to enhance the effectiveness and integrity of VA's use of VCAs, as well as the entire VCCP, by bringing that office's resources, data, and enterprise-wide view of VCAs and the VCCP to bear in a manner that will promote consistency and quality in how VA interprets and applies the impracticability standard in § 17.4120(d) of the interim final rule and that will ensure VA is appropriately assessing and accounting for the potential impacts, if any, of such determinations on the VCCP more broadly. Consequently, VA does not make any changes to the interim final rule based on these comments.

The same commenter also indicated that the non-VA entities and providers furnishing care pursuant to VCAs need to be adequately compensated on a timely basis for their services. In response, we note that VA agrees with this comment and will work to ensure timely payments for care and services obtained pursuant to VCAs, as required by 38 U.S.C. 1703D. All VCAs contain payment terms that require VA to make payment in accordance with the timeframes required by statute, so it would serve no relevant purpose to add those same payment timeliness requirements to this final rule.

Consequently, we do not make any changes to the interim final rule based on this comment.

The same commenter also asserted that VA must develop and partner with a network of dedicated providers and that service-disabled veteran owned small businesses (SDVOSB), veteran owned small businesses (VOSB), and prior VA clinicians should be given priority. The comment indicated that the reasons for recommending that VA prioritize utilization of SDVOSBs and VOSBs include that veterans (which we presume refers to the veteran owners of those businesses) have shared military experience that improves the efficacy of counseling services provided to fellow veterans and that such veteran owners are highly motivated, dedicated, and willing to make sacrifices to help their fellow veterans. As it pertains to the subject matter of this rulemaking, VCAs, we interpret this comment recommending that VA give "priority" to SDVOSBs, VOSBs, and prior VA clinicians to mean that when VA is obtaining needed hospital care, medical services, or extended care services for a veteran through a VCA, in accordance with the legal criteria for doing so,[4] two or more VCAs are feasibly available for that purpose, and one or more of those feasibly available VCAs was entered into with an entity that's an SDVOSB or a VOSB or with a provider that's a prior VA clinician, that VA should automatically obtain the needed care or services through one of the VCAs entered into with the entities and providers in those classes in lieu of using any other VCAs that are feasibly available. In response, we note that when the needed care or services at issue are being obtained through the VCCP, the veteran is legally permitted to select the eligible entity or provider from which the veteran receives such care or services.[5] So, implementing the commenter's

[4] As previously noted, the circumstances when VA is legally authorized to use VCAs to obtain hospital care, medical services, or extended care services are specified in 38 U.S.C. 1703A(a) and in § 17.4115(a) of the interim final rule.

[5] *See* 38 U.S.C. 1703(g)(2) ("[VA] shall not prioritize providers in a tier over providers in any other tier in a manner that limits the choice of a covered veteran in selecting a health care provider specified in

recommendation would not be legally feasible in that context if the veteran opts to select the eligible entity or provider. Moreover, if and when VA finds itself in the position of selecting from among multiple VCAs that are feasibly available for purposes of obtaining needed care or services, VA's determination of the appropriate VCA to utilize will be driven by clinical considerations, including those bearing on ensuring VA obtains timely and quality care and services most appropriate to the specific needs of the beneficiary. In some instances, the involvement of veterans or prior VA clinicians in the delivery of care and services by certain entities and providers could prove relevant to such individualized and clinically driven determinations. However, selecting the VCA that VA will use based upon whether the VCA was entered into with an SDVOSB, a VOSB, or a prior VA clinician, rather than based upon a holistic and individualized assessment of all relevant clinical considerations, including those bearing on ensuring VA obtains timely and quality care and services most appropriate to the specific needs of the veteran, could result in adverse consequences, including worse health outcomes, for the veteran. Consequently, we decline to adopt such an approach, and, for the foregoing reasons, we make no changes to the interim final rule based on this comment.

Administrative Procedure Act

VA has considered all relevant input and information contained in the comments submitted in response to the interim final rule (84 FR 21668) and, for the reasons set forth in the foregoing responses to those comments, has concluded that no changes to the interim final rule are warranted. Accordingly, based upon the authorities and reasons set forth in the interim final rule (84 FR 21668), as supplemented by the additional reasons provided in this document in response to comments received, VA is

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subsection (c) for receipt of hospital care, medical services, or extended care services under [the VCCP]"); 38 CFR 17.4030 ("[a] covered veteran may specify a particular eligible entity or provider").

adopting the provisions of the interim final rule as a final rule with no substantive changes.

Paperwork Reduction Act

The Paperwork Reduction Act of 1995 (44 U.S.C. 3507) requires that VA consider the impact of paperwork and other information collection burdens imposed on the public. Except for emergency approvals under 44 U.S.C. 3507(j), VA may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The interim final rule included provisions constituting new collections of information under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501-3521) that require approval by the Office of Management and Budget (OMB) (the provisions in the interim final rule are §§ 17.4110, 17.4130, and 17.4135). Accordingly, under 44 U.S.C. 3507(d), VA submitted a copy of the interim final rule to OMB for review, and VA requested that OMB approve the collections of information on an emergency basis. VA did not receive any comments on the collections of information contained in the interim final rule. OMB approved the collections of information under control number 2900-0872.

Regulatory Flexibility Act

The Secretary hereby certifies that this rule will not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act, 5 U.S.C. 601-612. Therefore, pursuant to 5 U.S.C. 605(b), the initial and final regulatory flexibility analysis requirements of 5 U.S.C. 603 and 604 do not apply.

Executive Orders 12866 and 13563

Executive Orders 12866 and 13563 direct agencies to assess the costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, and other advantages; distributive impacts; and equity). Executive Order 13563 (Improving Regulation and Regulatory Review) emphasizes the importance of quantifying both costs and benefits, reducing costs, harmonizing rules, and promoting flexibility. OMB's Office of Information and Regulatory Affairs (OIRA) has determined that this rule is not a significant regulatory action under Executive Order 12866. The Regulatory Impact Analysis associated with this rulemaking can be found as a supporting document at www.regulations.gov.

Unfunded Mandates

The Unfunded Mandates Reform Act of 1995 requires, at 2 U.S.C. 1532, that agencies prepare an assessment of anticipated costs and benefits before issuing any rule that may result in the expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of $100 million or more (adjusted annually for inflation) in any one year. This final rule will have no such effect on State, local, and tribal governments, or on the private sector.

Congressional Review Act

Pursuant to the Congressional Review Act (5 U.S.C. 801 et seq.), OIRA designated this rule as not a major rule, as defined by 5 U.S.C. 804(2).

Catalog of Federal Domestic Assistance

The Catalog of Federal Domestic Assistance numbers and titles for the programs affected by this document are as follows: 64.009, Veterans Medical Care Benefits; and 64.018, Sharing Specialized Medical Resources.

List of Subjects in 38 CFR Part 17

Administrative practice and procedure, Alcohol abuse, Alcoholism, Claims, Day care, Dental health, Drug abuse, Foreign relations, Government contracts, Grant programs-health, Grant programs-veterans, Health care, Health facilities, Health professions, Health records, Homeless, Medical and dental schools, Medical devices, Medical research, Mental health programs, Nursing homes, Philippines, Reporting and recordkeeping requirements, Scholarships and fellowships, Travel and transportation expenses, Veterans.

Signing Authority

Denis McDonough, Secretary of Veterans Affairs, approved this document on July 27, 2021, and authorized the undersigned to sign and submit the document to the Office of the Federal Register for publication electronically as an official document of the Department of Veterans Affairs.

Michael P. Shores*,*

Director,
Office of Regulation Policy & Management,
Office of General Counsel,
Department of Veterans Affairs.

Accordingly, the interim final rule amending 38 CFR Part 17, which was published at 84 FR 21668 on May 14, 2019, is adopted as final with the following technical amendments:

PART 17 – MEDICAL

1. The general authority citation for part 17 continues to read as follows:

AUTHORITY: 38 U.S.C. 501, and as noted in specific sections

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§§ 17.4110, 17.4130, and 17.4135 [AMENDED]

2. In §§ 17.4110, 17.4130, and 17.4135, remove the OMB statement "(The information collection requirements have been submitted to the Office of Management and Budget (OMB) and are pending OMB approval.)" and add in its place "(Office of Management and Budget approved the collection of information under control number 2900-0872.)".

[FR Doc. 2021-19470 Filed: 9/10/2021 8:45 am; Publication Date: 9/13/2021]